EXECUTIVE SUMMARY

PURPOSE

To examine the experiences of health maintenance organizations, particularly those participating in Medicare or Medicaid, in contracting with pharmacy benefit management companies.

BACKGROUND

MEDICAID AND MEDICARE COVERAGE OF PRESCRIPTION DRUGS

In 1994, national expenditures on prescription drugs were $52 billion, up from $21 billion in 1985. The Medicaid program accounted for $9 billion of these expenditures (8 percent of all Medicaid expenditures). The Medicare program has limited its coverage of outpatient prescription drugs to a few specific categories of drugs. But recently, many beneficiaries have been receiving broader outpatient drug coverage as an additional benefit offered by Medicare-risk health maintenance organizations (HMOs).

PHARMACY BENEFIT MANAGEMENT COMPANIES

Pharmacy benefit management companies (PBMs) have emerged as significant players that can help payers and health plans control rising drug costs and improve drug therapy of their providers and to their patients. The HMOs, among others, can contract with PBMs for services ranging from claims processing to disease management programs involving patients, pharmacists, and physicians.

THIS INQUIRY

This inquiry focuses on the experiences of HMOs in using PBMs. As enrollment in managed care continues grows and because PBMs can significantly affect patients' use of prescription drugs, it is important for the Health Care Financing Administration (HCFA), as well as private payers, to be informed about the HMOs' experiences with them.

This report is based primarily on data from a mail survey of all HMOs in the country, for which we had a 71 percent response rate. We also drew on discussions with staff from the U.S. Department of Health and Human Services (HHS) and several State Medicaid agencies; with non-government experts; and on a review of the literature.

EXPERIENCES OF HMOs WITH PBMs

WIDESPREAD AND GROWING USE OF PBMs

Three-fourths of the 263 HMOs responding to our survey contract with PBM companies. The number using PBMs has nearly tripled since 1993. A majority (74 percent) of these HMOs serve Medicare and/or Medicaid beneficiaries.

Nearly all HMOs use PBMs for services that affect patients' use of prescription drugs, such as managing formularies and reviewing drug therapy decisions of physicians, pharmacists, and patients.

In the future, many HMOs will use PBMs in ways that influence patient care even more directly through purchasing more clinically focussed services and through negotiating more capitated or risk-sharing contracts.

POTENTIAL COST-SAVINGS: THE BIGGEST BENEFIT

The HMOs describe the benefits of using PBMs mainly in terms of controlling costs of prescription drugs. They also consider other important benefits to be improving physicians' prescribing practices and patients' access to pharmacy services.

POTENTIAL BIAS: THE BIGGEST CONCERN

The HMOs' biggest concern about PBMs is the potential for bias resulting from the PBMs' alliances with drug manufacturers. One-half (52 percent) of the HMOs contract with one of the five, large PBMs, each of which is owned by or allied with drug manufacturers.

Other concerns to HMOs include confidentiality of data, disclosure of information to patients, and the HMOs' own oversight of the PBMs' performance.

MINIMAL OVERSIGHT OF PERFORMANCE

The HMOs rely primarily on PBM-supplied data and reports for overseeing their PBMs' performance. They rely less on independent assessments from their own clinicians and patients.

The HCFA and State Medicaid agencies we contacted provide minimal oversight of their Medicare and Medicaid HMOs' subcontracts with PBMs or their HMOs' pharmacy programs in general.

The major, private accreditation programs for managed care organizations neither accredit PBMs nor review HMOs' pharmacy programs and the arrangements they may have with PBMs. In part, this inattention reflects a lack of quality measures suitable for assessing pharmacy programs in these settings.

RECOMMENDATIONS

The HCFA should take steps to ensure that its Medicare HMOs are sufficiently accountable for the quality of the services their PBMs provide to beneficiaries.

The HCFA could take steps toward this end by strengthening its contract requirements for Medicare HMOs and by incorporating reviews of pharmacy programs in its oversight of the HMOs' performance.

Similarly, State Medicaid agencies should take steps to ensure that their Medicaid HMOs are sufficiently accountable for the quality of the services their PBMs provide to beneficiaries.

State Medicaid agencies could take steps similar to those suggested above for HCFA and its Medicare HMOs. The HCFA could work with States towards this end.

The HCFA, the Food and Drug Administration, and the Health Resources and Services Administration, working together with external organizations, should build on existing efforts to develop quality measures for pharmacy practice that can be used in managed care settings.

The pharmacy profession has begun to develop a framework of standards and measures that can be used to assess the quality of pharmacy services and programs. Continued development of this framework is essential. It needs to involve the significant parties who have responsibility for ensuring that pharmacy programs rest on foundations that are clinically sound, widely accepted, and promote improved patient care. These parties include the professional pharmacy and medical organizations, the private accreditation organizations, consumer groups, and the managed care industry.

COMMENTS ON THE DRAFT REPORT

We received comments on the draft report from the Health Care Financing Administration (HCFA), the Food and Drug Administration (FDA), and the Health Resources and Services Administration (HRSA). We also solicited and received comments from the Academy of Managed Care Pharmacy (AMCP), the American Medical Association (AMA), the American Pharmaceutical Association (APHA), the American Society of Health Systems Pharmacists (ASHP), the Consumer Coalition for Quality Health Care, and HCFA's Medicaid Pharmacy Technical Advisory Group. We include the complete text of the detailed comments in appendix D. Below we summarize the major thrust of the comments and, in italics, offer our responses. We made a few minor edits in the report in response to the comments.

HCFA, FDA, HRSA COMMENTS

All three agencies concurred with our recommendations.

In concurring with the first recommendation, HCFA identified current requirements for its contracts with HMOs and summarized its current approaches for monitoring their performance. *In our view, this response does not substantively address a central concern raised in this report about HCFA's minimal oversight of its HMOs' pharmacy programs and their subcontracts with PBMs. We believe our findings warrant more attention by HCFA. Its HMO contract, as we point out, could be an important vehicle for strengthening Medicare HMOs' accountability for their pharmacy programs.*

The third recommendation, for HCFA, FDA, and HRSA to work with external organizations on developing quality measures for pharmacy practice, was favorably received by all three agencies. We encourage the agencies to meet together and to identify one among them to assume lead responsibility, so that enhanced communication

and coordination may facilitate continued progress in developing these measures.

EXTERNAL ORGANIZATIONS' COMMENTS

All the outside organizations concurred with our recommendations. Some call for revisions to the report or other actions on our part. *We appreciate that these organizations support our recommendations. Unfortunately, many of the comments suggest actions beyond the scope of this inquiry.*